STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. B-02/09-94
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals a decision by the Office of Vermont Health Access (OVHA) denying a request for an increase in the number of physical therapy visits approved by OVHA for her minor son. The issue is whether the petitioner has demonstrated that her request meets the criteria for prior authorization under the applicable regulations.

Procedural History

OVHA authorizes physical therapy for four month periods. This case arose from a request petitioner made to OVHA to approve two physical therapy visits per week or thirty-four visits for the four month period starting November 16, 2008. OVHA approved eight physical therapy visits for the four month period.

Petitioner initiated the MCO (managed care) internal grievance procedure on November 19, 2008. OVHA issued a medical basis statement on November 28, 2008.

The internal grievance meeting took place on December 12, 2008. Petitioner submitted additional information. OVHA was asked to review this material and update their medical basis statement.[1] OVHA submitted an updated medical basis statement dated December 26 and 30, 2008.

On January 12, 2009, petitioner's internal appeal was denied. Petitioner filed for a fair hearing on February 5, 2009. A status conference was held on March 12, 2009 and deadlines set for pre-hearing memoranda. The fair hearing took place on April 20, 2009.

The following decision is based upon the testimony taken at fair hearing, stipulated exhibits, and hearing memorandum.

FINDINGS OF FACT

1. Petitioner brings this case on behalf of her son, G.R. G.R.'s date of birth is May 14, 2005; he is four years old. Petitioner's son receives Medicaid funding for physical therapy. G.R. has a personal care attendant who provides care twenty to fifty hours per week.

2. G.R. suffered a stroke in utero and has been diagnosed with right hemiparesis. He has significant weakness on his right side. G.R. periodically has seizures.

[1] When new material is submitted to OVHA, their practice is to review the materials, review their decision, and update the medical basis statement.

He had major seizures during July and October 2008 that caused him to regress functionally for a period of time.

3. G.R. receives physical therapy, occupational therapy, and speech language therapy from a number of sources. Until G.R. turned three years old, certain of his services were paid through FIT (Families, Infants and Toddler Program) and the Children with Special Health Needs Program. Since G.R. turned three years old, he has received services through Medicaid, the school (early essential education), and private pay.

4. S.M. is a physical therapist and consultant to OVHA. She has been involved in petitioner's requests for physical therapy since November 2005.

S.M. analyzed the history of OVHA authorizations for physical therapy since November 15, 2005. Over time, OVHA has tapered the number of visits approved per four month period. G.R. was granted the following Medicaid coverage for physical therapy from OVHA:

a)	11/15/05 to 3/14/06	17 visits
b)	3/15/06 to 7/16/06	17 visits
c)	7/16/06 to 11/15/06	17 visits
d)	11/16/06 to 3/15/07	16 visits
e)	3/16/07 to 7/15/07	15 visits
f)	7/16/07 to 11/15/07	14 visits
g)	3/16/08 to 7/15/08	10 visits
h)	7/16/08 to 11/15/08	8 prorated to 7 visits

S.M. approved the tapering of physical therapy visits for each four month period. It should be noted that the initial authorization for seventeen visits is equivalent to one visit per week.

Because G.R. received coverage for physical therapy from other sources, he actually received physical therapy services averaging from two to five visits per week.

5. Petitioner submitted the following information from G.R.'s medical providers over the course of the appeal:

a) December 2, 2008 letter from Dr. L.K. recommending that G.R. receive physical therapy twice per week for optimal development.

b) December 8, 2008 letter from Dr. R.C. (pediatrician) that G.R. needs intensive physical therapy twice weekly for optimal progress. Dr. R.C. wrote that without these services, G.R. is "likely to suffer life-long disability".

c) December 12, 2008 letter from M.M., G.R.'s physical therapist, noted intensive physical therapy services for the past 1.5 years including services 5 times per week until a recent reduction to 2-3 times per week. She wrote:

> He is running independently, climbing, kicking balls with either foot, catching and throwing balls with both hands, and is beginning to jump. He would continue to benefit from intense physical therapy services for balance training, gait training, strengthening, aquatic therapy and facilitation of age appropriate gross motor skills.

M.M. cited several studies in support of the request.

d) January 30, 2009 letter from Dr. S.B. (FAHC physical medicine/rehabilitation) supporting petitioner's request by noting that G.R. responds well to aggressive therapies. Dr. S.B. treats G.R. with botox injections to his right upper extremities and prefers not to add botox injections to G.R.'s right lower extremity to avoid additional pain and to maintain the effectiveness of current botox treatment. Dr. S.B. wrote:

> When decreasing frequency of therapies, [G.R.] is a child who seems to regress a little bit in regard to his skills. While this is not characteristic of all children with hemiplegia, [G.R.] seems to respond extremely well to more aggressive therapies. In order to maximize his overall growth and development, both from a development standpoint, as well as a musculoskeletal standpoint,...necessary for him to have physical therapy services twice weekly to continue working on gait training, range of motion, weight bearing stimulus and improvement in overall motor coordination and balance skills.

e) Letter dated February 6, 2009 from Dr. L.K., pediatric neurologist supporting petitioner's request. According to Dr. L.K., G.R. has responded well to intensive interventions, especially his motor skills. She added:

> ...the brain exhibits the greatest plasticity in early childhood...time that attention to maximizing strength and function of a hemiparetic limb is most important. Without particular attention to exercise and use of his right side, [G.R.] is at risk of losing function as well as developing contractures and atrophy. His greatest chance of functioning independently in the long term comes from an intensive effort now to exercise and strengthen his right side. This will help to increase cortical connections to the right side of his body and minimize long term disability.

f) February 4, 2009 letter from M.M. stating that G.R. has not progressed as well due to a reduction in his physical therapy services over the past four months.

> She explained that G.R. becomes more asymmetrical when he is going through growth spurts and that more aggressive therapy is needed. She noted that G.R. took two to three weeks to bounce back from his July seizure and six to eight weeks to bounce back from his October seizure.

6. S.M. has been consistent in her reasoning throughout this case. As she updated the medical basis statements, her analysis and reasoning have remained the same. S.M. reviewed the petitioner's documentation and independently reviewed the national data bases regarding the efficacy of high intensity physical therapy services for children. S.M. based her decision, in part, on the practice norms for physical therapists that high intensity services are used the first year of services with subsequent tapering of services, and, in part, on the lack of evidence based research supporting high intensity services for children after the first year of service.

S.M. stated that G.R. received intensive services the first year and that OVHA has tapered the number of visits for each period until reaching eight visits per four month period to allow for review and adjustment by the physical therapist working with the family. A key component of a physical therapy program is the work done by family members and caregivers on a daily basis. S.M. noted her concerns that

continuing high intensity services could lead to the family's dependence on the therapist.

Under the EPSDT program, G.R. is eligible for maintenance physical therapy services until he reaches the age of twenty-one years. She noted that petitioner could request more services if G.R. suffered a setback or growth spurt or other reason to increase services for a time.

7. The MCO appeal was conducted by J.A., a physical therapist. The review process included a meeting with petitioner, S.M., and G.N., OVHA Grievance and Appeal Coordinator.

J.A. stated in the rationale for her decision that:

> Careful literature review yielded few studies that specifically explored the question posed by [petitioner] however it was possible to come to an evidence based conclusion to support the denial based on the following resources.
>
> The pertinent resources used by J.A. are:
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> 1) American Physical Therapy Association's *Guide to Physical Therapy* (2001) that lists 90 visits as the maximum number for children with G.R.'s condition.
>
> 2) A randomized study of 75 children who had strokes in utero finding that intensive physical therapy services after the child's first year did not show benefits as compared to a control group receiving periodic assessments.[2]

[2] Weindling, Cunningham, Glenn, Edwards, and Reeves. *Additional therapy for young children with spastic cerebral palsy: a randomized controlled trial*. Health Technology Assessment, 2007 11(16)1-71.

3) Analysis of current literature indicating lack of support for extensive physical therapy for extended periods.[3]

Based on J.A.'s decision, OVHA sent Notice on January 12, 2009 that her appeal was denied.

8. M.M. testified at hearing. M.M. has been a physical therapist for over twenty-three years; she has an advanced master's degree. She recommends that G.R. receive physical therapy two times per week.

M.M. has been working with G.R. for two years. M.M. described G.R. when she first began working with him. G.R. was nonambulatory. He sat on his left side; he scooted on his left side. As G.R. became ambulatory, he favored his left side.

M.M. testified that G.R. is asymmetric. He experiences muscle tightness. He has issues with gait and balance.

M.M. uses exercises that address weight-bearing, strength, range of motion, gait and balance. Because of G.R.'s age, M.M. incorporates physical therapy through play. M.M. works with both the family and G.R.'s personal care attendant on a regular basis to guide them in G.R.'s home program which incorporates stretching, range of motion, and

[3] Antilla, Suoranta, Malmivaara, Autti-Ra. *Effectiveness of physiotherapy and conductive education intervention in children with cerebral palsy: a focused review*. Am J Phys Med Rehabil 2008; 87:478-501.

play activities (e.g. pedaling a bike, jumping on a small trampoline).

M.M. explained that a trained physical therapist has knowledge and observational skills (eyes) that a family member or attendant may not have. In other words, she can see whether the child is doing the exercise correctly or compensating in a way that undermines the purpose of the exercise. By decreasing her visits, her ability to ensure that the child and his/her family or caregiver is doing the program correctly is diminished.

M.M. described certain setbacks. G.R. had major seizures during July 2008 and October 2008. His gait became more asymmetrical and he was more unbalanced. M.M. testified that G.R. took longer to recover in October because his physical therapy sessions were reduced in October. M.M. also explained that G.R. has minor setbacks during growth spurts because his muscles need to stretch out to deal with his longer bones.

M.M. is concerned that if GR does not receive adequate physical therapy that he may develop orthopedic issues in the future such as scoliosis, increased muscle contractions and tightness.

9. Petitioner testified. Petitioner explained that her goal is for G.R. to be fully functional bilaterally.

G.R. has a home program. Petitioner explained that the physical therapist provides training to her and the personal care attendant. Their home program includes running, jumping, hopping, balance, stretching, and weight bearing exercises. Petitioner explained that the physical therapist has equipment she does not have such as climbing equipment, swings for balance. She noted that she relies on the physical therapist's eyes to pick up what she is unable to see.

Petitioner testified that G.R. has regressed when his therapy has been reduced. His balance is affected and his lower body is affected.

10. S.M. testified. She has not met G.R.[4]; she performed a paper review. S.M. has spoken to the different physical therapists since November 2005 who have provided services to G.R.

S.M. relied on current standards and practices from the American Physical Therapy Association (APTA) to support her opinion. The APTA uses a maximum of ninety visits for a child such as G.R.

[4] S.M. has met applicants in other cases.

S.M. placed great weight on whether there are evidence based studies to support petitioner's position.[5] S.M. testified that there are not many studies that have addressed petitioner's request.

S.M. testified that she reviewed all the materials petitioner supplied including articles, information gathered on the internet, and materials cited by G.R.'s providers. She testified that the materials were not evidence based and many materials did not address the issue before her. S.M. testified that she independently searched national databases for evidence based studies regarding the efficacy of continuing high intensity physical therapy services. Not finding studies, S.M. believes petitioner's request is experimental because there are no studies supporting petitioner's request.

S.M. testified to her concerns that there is a danger of learned dependence in this case by over-reliance on professional physical therapists.

S.M. testified that each case needs to be looked at individually since each person is unique. She testified that

[5] Evidence based outcomes are based upon studies with statistically significant samples whose results have been replicated over time.

there are outliers for whom a particular evidence-based practice may not work.

S.M. was questioned how she would handle a case in which there was a paucity or no evidence based studies. She did not directly answer these questions but indicated that her decision is based on the research she finds.

ORDER

OVHA's decision is reversed.

REASONS

A request for prior authorization will be approved if the request meets the criteria found in M106.3 which states:

> A request for prior authorization will be approved if the health service:
>
> 1. is medically necessary (see M107);
> 2. is appropriate and effective to the medical needs of the beneficiary;
> 3. is timely, considering the nature and present state of the beneficiary's medical condition;
> 4. is the least expensive, appropriate health service available;
> 5. is FDA approved, if it is FDA regulated;
> 6. is subject to a manufacturer's rebate agreement, if a drug;
> 7. is not a preliminary procedure or treatment leading to a service that is not covered;
> 8. is not the repair of an item uncovered by Medicaid;
> 9. is not experimental or investigational;
> 10. is furnished by a provider with appropriate credentials.

The crux in petitioner's case is how medical necessity is defined for Early Periodic Screening, Diagnosis and Treatment (EPSDT) eligible beneficiaries. M107 states:

> "Medically necessary" means health care services, including diagnostic testing, preventive services, and aftercare, that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the beneficiary's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar specialty as typically treat or manage the diagnosis or condition, and
>
> 1. help restore or maintain the beneficiary's health; or
>
> 2. prevent deterioration or palliate the beneficiary's condition; or
>
> 3. prevent the reasonably likely onset of a health problem or detect an incipient problem.
>
> Additionally, for EPSDT-eligible beneficiaries, medically necessary includes a determination that a service is needed to achieve proper growth and development or prevent the onset or worsening of a health condition. (emphasis added)

It should be noted that the federal Medicaid program treats adults and children differently. The federal mandates are incorporated in the following language from M100:

> The scope of coverage for children under . . . EPSDT . . . is different and more extensive than coverage for adults. The EPSDT provisions of Medicaid Law specify that services that are optional for adults are mandatory for all Medicaid-eligible children . . .

Congress did not define "medical necessity" in the Medicaid program but left the States with discretion to define the terms and operation of "medical necessity". However, Congress has placed broad parameters upon the terms and operation of "medical necessity" in EPSDT cases. 42 U.S.C. § 1396d(r)(5). "While States may use prior authorization and other utilization controls to ensure that treatment services are medically necessary, these controls must be consistent with the preventive thrust of the EPSDT benefit." H.R. Rep. No. 101-247 at 398-400 (1989) reprinted in 1989 U.S.C.C.A.N. 1906, 2125.

M100 incorporates 42 U.S.C. § 1396d(a)(13) which requires States to provide EPSDT-eligible children with:

> . . . other diagnostic, screening, preventive, and rehabilitation services including any medical or remedial services (provided in a facility, home, or other setting) recommended by a physician or other licensed professional of the healing arts within the scope of their practice under State Law, for the maximum reduction of physical or mental disability and restoration of an individual to the best functional level. (emphasis added)

In creating the Medicaid program, the federal government took special care to provide for the needs of children. Rosie D. v. Romney, 410 F.Supp.2d 18 (D.Mass. 2006 at page 25, "As broad as the overall Medicaid umbrella is generally, the initiatives aimed at children are far more expansive.").

In petitioner's case, OVHA used a narrow focus in its determination that the physical therapy request was not medically necessary. In particular, OVHA relied on the absence of research that intensive physical therapy services are beneficial over time for children. In doing so, OVHA determined that intensive physical therapy services are experimental. The physical therapy exercises are not in dispute; the frequency of physical therapy visits with a trained physical therapist is in dispute.

There are several problems with OVHA's reasoning. First, OVHA recognizes that few studies have actually looked into the efficacy of long-term intensive physical therapy for children who suffered strokes in utero. Second, assuming for argument that sufficient evidence based research exists, OVHA did not consider whether this particular child is an outlier for whom a different result is necessary. The Medicaid program mandates an individualized review; such a review does not rest upon a literature review. Jacobus v. Dept of PATH, 177 Vt. 496 (2004). Third, OVHA's review fall within the parameters of "medical necessity" for adults and not the more expansive "medical necessity" standards for children that focus on achieving proper growth and development or

preventing the worsening of a condition. In all, OVHA's analysis is too narrow.

Although OVHA's focus has been too narrow, the issue still remains whether the petitioner's request is medically necessary. Petitioner's request for fair hearing triggers a de novo hearing in which she bears the burden of proof in showing the medical necessity for the requested amount of physical therapy.

Petitioner's goal for her son is to function bilaterally. To that end, she has advocated for intensive services and obtained those services until recently. The evidence focuses on both prongs of the EPSDT program—achieving proper development and preventing the worsening of G.R.'s functioning.

M.M. has been G.R's physical therapist for two years. She works in tandem with petitioner and G.R.'s personal care attendant to provide a program that strengthens G.R.'s right side and his ability to use his right limbs. M.M. has seen G.R. benefit from intensive services. In contrast, she has seen the impact upon G.R. when those services were not available. G.R. had seizures in July and October; seizures caused G.R.'s functioning to regress. G.R.'s recovery period

was twice as long in October, a period in which his services had been reduced.

G.R. is treated by Dr. L.K., a pediatric neurologist, and Dr. S.B., physical medicine and rehabilitation. Both support petitioner's request. Dr. L.K. wrote that the intensive services are needed in early childhood to maximize strength and functioning of limbs due to the brain's greater plasticity during this period. In addition, she wrote that decreased services can lead to loss of function due to contractures and atrophy of muscles. Dr. S.B. concurred and explained that G.R., unlike many other children with hemiparesis, is a child who responds well to aggressive intervention. Both speak to the need to minimize disability.

The medical professionals who have been intimately involved with G.R.'s care and development support petitioner's request.[6] In contrast, OVHA relies on a paper review. The parties differ on the weight to be given to G.R.'s medical providers. It should be noted that courts also differ on whether the person's treating physician's

[6] This case stands in contrast to Fair Hearing No. T-04/08-164 and Fair Hearing No. T-05.08-223 in which the petitioner did not supply documentation from her children's' medical providers supporting the request for a certain number of occupational therapy sessions with a professional. Here, petitioner has amply provided medical documentation of the need for intensive professional services.

recommendation is the sole criteria for determining medical necessity.

OVHA argues that the person's physician is not the sole arbiter of medical necessity. Moore v. Medows, 2009 U.S. App. Lexis 8718 (11th Cir. 2009) (per curium opinion reversing summary judgment based on physician's decision that a certain level of skilled nursing care was needed for a severely disabled child and remanding case to determine medical necessity in that both the state and treating physician have roles to play); Rush v. Parham, 625 F.1150 (5th Cir. 1980)(that physician take note of reasonable limitations state uses in determining medical necessity such as a ban on experimental treatments, case remanded to determine if gender reassignment surgery falls within experimental treatment); Cowan v. Myers, 187 Cal. App.3d 968 (Cal. App. Dist.3 1986)(that State regulations are in violation of State statute. Part of case discusses role of the physician and finds that the State determines what type of services can come under its program and then physician decides whether the patient's treatment falls within the type of service.)

Petitioner argues that deference should be given to the treating physician given his/her greater familiarity with the patient's condition and treatment needs. Rosie D., *supra*;

Urban v. Meconi, 930 A.2d 860 (DE 2007)(State should give "substantial weight" to treating doctors' opinions and less weight to opinion of nontreating doctor. Found State improperly denied request for surgery under EPSDT program.); Pediatric Specialty Care, Inc. v. Arkansas Dept. of Human Services, 293 F.3d 472 (8th Cir. 2002)(on pg. 480, "...holds that a Medicaid-eligible individual has a federal right to early intervention day treatment when a physician recommends such treatment."). See also Weaver v. Reagen, 886 F.2d 194 (8th Cir. 1989) and Hilburn by Hilburn v. Maher, 795 F.2d 252 (2nd Cir. 1986) for proposition that deference is given treating doctors in Medicaid cases.

Petitioner also argues that a physician's recommendation should be dispositive. The Court in Rosie D., *supra* at page 26 stated:

> Courts construing EPSDT requirements have ruled that so long as a competent medical provider finds specific care to be "medically necessary" to improve or ameliorate a child's condition, the 1989 amendments to the Medicaid statute require a participating state to cover it. *See, e.g., Collins* 349 F.3d at 375 (holding that if a competent medical service provider determines that a specific type of care or service is medically necessary, state may not substitute a different service that it deems equivalent); *see also Rosie D.*, 310 F.3d at 232; *John B. v. Menke*, 176 F.Supp.2d 786, 800 (M.D.Tenn. 2001)(noting that a state "is bound by federal law to provide 'medically necessary' EPSDT services").

The Board need not reach the argument whether a physician's recommendation is dispositive. The Board decisions find that the opinions of treating medical providers are to be given deference provided that the medical providers do not merely state conclusions but provide sufficient information regarding diagnosis, treatment, and prognosis. Fair Hearing Nos. 21,077 and B-02/08-72.

The petitioner has met her burden of proof through testimony and documentary evidence in the record. OVHA relied on a paper review that focused on the general norms applicable to physical therapy rather than the type of individualized review contemplated in EPSDT cases. In contrast, the petitioner's evidence from her child's medical providers meets either of the two EPSDT standards—(1) maximizing G.R.'s development and growth and (2) preventing deterioration. As a result, OVHA's decision is reversed. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 1000.4D.

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